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ABSTRACT

The traditional psychological assessment approach leaves much to be desired if one considers man to be more than a body or a machine. It fails to consider his humanity, self-respect, intentions, and goals. The author discusses his own assessment procedure which involves a six-hour structured group with up to 20 patients and eight staff members. Structured into this approach are several processes: (1) having the patient participate in his own evaluation; (2) involving the staff and patients in a process of mutual self-disclosure; (3) providing feedback during and at the end of the assessment process; and (4) merging the diagnostic and therapeutic approaches in a time-limited structured group. The group serves at least three functions: diagnostic, therapeutic, and educational. A breakdown, hour by hour, of the group process is provided, as well as suggestions for improving the process.
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PSYCHOLOGICAL ASSESSMENT ON THE BASIS OF COLLAGE AND GROUP PROCESS

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INTRODUCTION

Gordon Allport once said that if you want to know something about a person, begin by asking him. Most psychological assessment approaches have implicit in their structure a request for the patient to disclose himself so as to be understood by another person. However, how one goes about this request makes a great deal of difference. The traditional assessment approach derived from the medical model begins with a referral for differential diagnosis or treatment recommendations and ends with a report sent in confidence to the referral source and frequently kept secret from the patient. Between the referral and the report, tests of various kinds may be administered which may appear mysterious or irrelevant to the patient, who is expected to cooperate nevertheless. It is as if our traditional psychological assessment approach is based on an adversary system wherein the patient is perceived as unable or more likely unwilling to reveal himself. We expect him to be "defensive" or to "lie" so we design tests with validity scales as on the MMPI or we make the task ambiguous as on the Rorschach so we can learn something about the patient in spite of his resistance or defensiveness. Even if we don't see the patient as an adversary, we frequently assume he is unable to understand or may misinterpret the results and for that reason keep the data from him. Regardless of the dynamics of the testing process the pay off is frequently that the patient gets little or nothing in return for his time and effort which may be considerable. Complicating the issue is the fact that often the

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test sample of behavior is far removed from the actual behavior to be predicted. While the clinician may very well be able to make the necessary inferences, the patient can only experience such testing as irrelevant, boring, or threatening. The traditional approach leaves much to be desired if one considers man to be more than a body or a machine, (Fisher, 1970); it fails to consider his humanity, his self respect, his intentions, and his goals.

REVIEW OF THE LITERATURE

There is a vast amount of literature in the area of self disclosure summarized most recently by Cozby (1973). Of the many variables involved in facilitating self disclosure on the part of the patient, there appears to be a positive correlation between patient and clinician self disclosure. However, this relationship may be curvilinear. There may be a modicum or an intermediate amount of self disclosure on the part of the clinician with extremes in either direction having undesirable effects (Giannandrea, 1973). This suggests that the clinician must be neither a "great stone face" nor a "good joe" if he is to elicit maximum self revelation on the part of his patients. Weigel (1972) suggests that the absolute level of clinician self disclosure may not be as important as the discrepancy between clinician self disclosure and patient expectation. Depending on the patient's role expectations of clinicians, self disclosure could lead the patient to make negative evaluations of his mental health, his competence and his professional ethics. Dies (1973) research suggests that the timing of such self disclosure may be an important factor also.

Another way of looking at the problem is to consider self disclosing behavior on the part of staff to be a model for desired group behavior. The willingness of staff participants to be personally open and self revealing in the context of an assessment situation may create the climate wherein patients will expect to be rewarded for similar behavior (Dies, 1973). Sarason (1972) suggests that this modeling can help to clarify and accelerate the therapeutic process. Truax (1965) raises this important question: can clinicians who are unwilling or unable to reveal themselves to patients expect patients to be open and self disclosing? Jourard (1970) suggests that the most effective means of inviting a person to disclose himself is for the staff person himself to engage in similar activity.

Still another way of understanding the effect of mutual self disclosure is described by Worthy (1969), who suggests that much social interaction can be explained in terms of payoffs or outcomes, and that interactions are engaged in as an effort to maintain some kind of balance. Thus there may be a tendency on the part of the patient toward reciprocity. If the clinician reveals himself, the patient may also tend to reveal himself resulting in a complete transaction.

PROCEDURE

The possibility of modifying my own rather traditional approach to assessment occurred about a year ago when, in collaboration with my colleagues, I began a group assessment procedure to provide diagnostic formulations and treatment recommendations for a rather large group of

people for whom MMPI and other group testing data was insufficient and individual testing impractical. The following description is the result of one year of experimentation which is still in process. Structured into this approach are several processes: having the patient participate in his own evaluation to the extent of creating his own instrument and defining his own symbols; involving the staff and patients in a process of mutual self disclosure; providing feedback during and at the end of the assessment process; merging of diagnostic and therapeutic approaches in a time limited structured group. These processes are combined in a structure described below as the diagnostic group.

The diagnostic group is a six hour structured group involving up to twenty patients and eight staff. The six hours are divided into two sessions of three hours each separated in time by one week. Referrals from both inpatient and outpatient staff include patients with low motivation for treatment; patients who aren't benefiting from existing hospital treatment structures; patients whose personality structure and psychodynamics are poorly understood; patients who may benefit from a brief therapeutic group experience. Excluded are patients in acute crisis or with poor ego defenses who may not tolerate the intensity of three hours of interaction or a large group experience. The staff consists of a core group with experience leading groups and some understanding of the diagnostic group's structure and conceptual basis. Outside this core group are staff in training who are paired with experienced staff. While both large and small group interactions are utilized in the diagnostic group, much of the process is focused on small groups consisting typically of four patients and two

staff. The following is a breakdown hour by hour of the diagnostic group process.

1. The first hour is devoted to four basic tasks: getting acquainted; expressing mutual expectations of both staff and patients; establishing a contract; constructing a collage.

The first task is initiated by having both staff and patients participate in structured exercises in pairs, groups of four and groups of eight leading finally to each person presenting himself in front of the total group.

The second task is begun with the group leader's expectation that participants be as open and honest as possible and that they be present for all six hours. Group members are asked to express their positive and negative expectations.

The third task, the contract, is very important. The leader asks them to identify specifically as possible what they want out of the six hours together. They are told that the referring team or physician will receive a written report following the group feedback session but that they also will receive feedback during the group itself as well as during the final hour. Thus, they are promised something in return for their participation. To clarify further the contract they are told that the staff will at the same time be participating with them in the group process and will be making observations in writing from time to time as they gather data for the final report. It might be noted here that staff members are integrated rapidly into the group via getting acquainted exercises, sharing of expectations, fears and hopes, and by sharing their collages. They participate

minimally during the middle phases when they are taking notes. They again participate fully during the final feedback session.

The fourth task which consumes the last half of the first hour is spent in collage construction. Instructions are given to look thru a large collection of magazines which includes old issues of Life, Look, Playboy, Newsweek, Better Homes and Gardens, National Geographic, etc., for pictures which have some appeal to them. When group members have found and cut out several pictures, they are instructed to arrange them any way they wish on a blank sheet of paper 18 x 21 inches in size and to glue them in place using the space in any way they like, one or both sides. They are told that any arrangement is ok and that there are no right or wrong pictures or arrangements. The task is usually done alone without help or criticism from staff or other patients. Because it occurs during the last part of the first hour, construction of the collage provides a good escape from the intensity of the large group; it is relaxing and fun for most people; it provides the basis for further interaction.

Thus having constructed their own projective instrument, the task of the second hour is one of helping group members to define their own symbols and to share those definitions with a small group of people with whom they will spend much of the remaining time. All six of the small group members are asked in turn to share the meaning of the symbols, pictures, colors and content of their collage. Next they are asked to choose two items in the collage, concepts or pictures which have some significance to them: one which has particular positive appeal and one which has particular negative appeal. In order to concretize the effect associated with these opposite themes, each person is asked to take the role, first of the positive

theme and then of the negative theme. Taking the role requires that they attempt to become that object, to give it a voice, to describe themselves "as if" they were the object. In this way they experience the feelings associated with the symbols more deeply than simply talking about them. Since these are opposite feelings in each of the two roles, a dialogue between the two roles helps to clarify ambivalence and integrate opposite feelings. They are asked to change chairs as they change roles. Some patients are unable to assume roles and act "as if." Others find it difficult to enter into dialogue and use the empty chair. Others fall easily into both role playing and dialogue. This data is useful in making treatment recommendations for Psychodrama and Gestalt approaches. In addition, considerable data are obtained from the content of the collage; from the meaning each gives to his symbols; from his use of color; his method of selecting the pictures and their arrangement on the page; from the best and least liked pictures; from the conflicts which the patient has identified for himself out of his own collage.

3. The third hour, the final hour of the first session, is spent without the collage dealing with unfinished business in the patient's past. Sharing of early memories may be used as a warm up here followed by identification of an important person from the past, usually a parent, authority figure or former spouse about whom they have unresolved conflicts or unexpressed feelings either positive or negative. The patient may speak to an empty chair or choose someone to represent the object of his feelings. Staff may double with the patient here, helping him express feelings which are difficult for him to handle, usually anger but sometimes appreciation.

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4. The fourth hour may begin with warm up exercises done in pairs which help the patient look realistically at his strengths and weaknesses and may also reveal negative self images as well as grandiose thinking. Group members are asked to brag on themselves to another person and then to share with that same person some of their negative qualities. Both skills and personality characteristics are considered. The remainder of the hour is spent exploring current interpersonal relationships by means of a sociogram. Each patient is asked to place other group members spatially and posturally to represent their feelings of distance and closeness regarding family or other relationships. Frequently this elicits spontaneous verbalization regarding the patient's relationships with people and this may be discussed further in the small group.

5. The fifth hour is spent focusing on the future. It may begin by a three day fantasy where patients are encouraged to let their imaginations go and think about what they would do for three days if there were no limitations as to money, job or health. After sharing that fantasy with the small group they are asked to pretend they have only twelve months to live, that they have a physical illness which is terminal but they will be able to function well to the very end. What is most important for them to do during that period? This is shared with the small group. Finally they are asked to do a future projection, to select some time in the future and specify who they are with, what they are doing, where they are and what they are experiencing. They may be asked to act out that future having people in the small group take the necessary roles. All three tasks may be quite difficult for depressed patients and for patients who are impulsive and tend

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to live in the present primarily. However, it is an important hour in that it gives some clue as to the patients reality testing and readiness for discharge.

6. The sixth and final hour is devoted to feedback. After a break where staff get together to integrate their observations and where patients are asked to think about what they have learned about themselves, the patients are asked to pair off and share with that person what they have learned. They then return to their small group for the final feedback session. The specific technique used is the Behind the Back Technique. Each person, both staff and patient, is asked to take his turn receiving feedback. The target person is asked to remain in the group but to turn his chair to the outside. The group then talks about him as if he is absent. He is not to respond until he is asked to rejoin the group. Thus feedback is given in an indirect manner making it less anxiety provoking for everyone. Data for the feedback is gained from the collage, social interaction, the patients' verbalizations, his nonverbal behavior and any additional data generated in the group. When feedback is complete for one individual, he is asked to rejoin the group by turning his chair around. Another person in the group is asked to summarize the feedback and only then is the patient given the chance to respond to the feedback.

This concludes the formal part of the diagnostic group. The staff pairs responsible for each group of four patients discuss each patient, fill out a check list of behavioral observations and a summary face sheet for each patient, making treatment recommendations as well as diagnostic impressions.

These reports are then made available to the treatment teams and referring physicians within a few days.

DISCUSSION

The diagnostic group process, from initial construction of the collage to psychodramatic exploration of interpersonal relationships to final feedback, involves both staff and patients in a self disclosing group interaction which has proved to be informative, educational and enjoyable. The patient learns that staff is human; staff members learn new therapeutic interactions by experiencing them and learn to know their patients better also. Patients frequently return to the wards with enthusiasm and with motivation to begin working on themselves or to make active plans for discharge. They also spread the word to other patients who then may actively seek to be included in the next diagnostic group or in a psychodrama treatment group. Thus, there are at least three functions served by the diagnostic group: diagnostic, therapeutic, and educational.

Possible changes in the future might include an additional hour devoted to video tape of group interaction and watching that interaction in a feedback session. Further development of the list of behavioral observations and the summary face sheet could make it more readily understandable for everyone concerned, both observers and referral source. The entire process could be more structured with manuals and outlines of the process and rationale as well as developing reusable pictures for collage work. Much of this development would be in the direction of making it possible for other staff members to direct the group as well as standardizing the process as a first step in determining its effectiveness in patient assessment and

treatment as well as in training of staff.

Footnote

1. This paper was presented at the American Psychological Association annual meeting, August 31, 1974, New Orleans, Louisiana. The symposium of which it was a part was entitled "The Client as Collaborator in the Assessment Process."

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